FORM 123

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 123
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA BOARD NO.
§37 or §37A
Claim

AGREEMENT UNDER SECTION 37 or 37A

Please print or type.

EMPLOYEE	1. Employee's Name (Last, First, MI):	
	2. Home Address (No. & Street, City, State, Zip Code):	
	3. Employer's Name:	
	4. Employer's Address (No. & Street, City, State, Zip Code):	
INSURER	5. Insurance Carrier's Name:	6. Insurance Company Address:
	7. Name & Address of Person Able to Verify Information:	
	8. Telephone Number:	

9. Paid Through (mm/dd/yyyy):	10. First Date of Disability (mm/dd/yyyy):	11. If Employee Died, Enter Date of Death:

12. Total Amount to be reimbursed under Section 37 ☐ or 37A ☐: $_____ (Check all that apply to this agreement) ☐ NEGOTIATED ☐ FULL & FINAL

13. Amount of Quarterly Reimbursements (if any): $_____

14. Is employee still receiving weekly compensation benefits? Yes ☐ No ☐ If Yes, please fill out the following

TYPE OF WEEKLY COMPENSATION	COMPENSATION AMOUNT
a. ☐ Total Disability – Temporary (§34)	$_____
b. ☐ Total Disability – Permanent (§34A)	$_____
c. ☐ Partial Disability (§35)	$_____
d. ☐ Dependent Coverage (§35A)	$_____
e. ☐ Surviving Dependents Coverage (§31)	$_____
f. ☐ Other (Specify) _____	$_____

I hereby certify that the information contained herein is a true accounting of all payments made to the above named employee.

_____ _____
Signature of Insurer's Authorized Representative — Prepared Date (mm/dd/yyyy)

_____
Name & title (Last, First, MI)

I hereby agree to and approve the following reimbursement to be made per the provisions of this agreement.

_____ _____ _____
Signature for the Office of Legal Counsel — Date (mm/dd/yyyy) — Name & title (Last, First, MI)

I hereby agree to and authorize the following reimbursement to be made per the provisions of this agreement.

_____ _____ _____
Signature for the Office of the Commissioner — Date (mm/dd/yyyy) — Name & title (Last, First, MI)